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UTILIZING MALPRACTICE CLAIMS DATA FOR QUALITY IMPROVEMENT

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Approximately 1400 malpractice claims were reviewed to identify and categorize patterns of error. The errors were grouped into the following three categories: problems in health care team coordination; patient management errors; and failure of technical performance. (Table 1)

ERROR TYPES BY SPECIALTY

	OB/GYN	SURGERY	ANESTHESIOLOGY	RADIOLOGY
Patient Management	57%	52%	48%	76%
Technical Performance	35%	37%	45%	18%
Coordination Problems	8%	11%	7%	6%

TABLE 1

Coordination problems included events such as a surgeon not telling an infectious disease consultant about a patient's penicillin allergy and an intern failing to awaken the attending obstetrician after observing late decelerations. Patient management errors included ordering the wrong medication and proceeding with a surgical procedure when a nonoperative strategy was indicated.

Failure of technical performance included inadvertent severing of the ureter during gynecologic surgery as well as clamping the wrong artery during abdominal surgery. Specialty areas surveyed included obstetrics and gynecology, general surgery, anesthesiology, and radiology.

Review findings demonstrated that patient management errors appeared most frequently in all four specialties (48% to 76%), and these management errors were generally associated with more serious injury and higher median payments. Within the patient management category, diagnosis and decision errors predominated, especially in radiology and obstetrics/gynecology. Coordination problems were less frequent (9%), while the third category, technical performance problems, fell in between.

There also was an interesting mix of error patterns within the same specialty. In obstetrics and gynecology, for example, newborn delivery claims were usually related to management errors (57% to 68%) whereas gynecologic procedure claims were most often associated with performance errors (55% to 73%).

The common thread running through all specialties and error categories seemed to be impaired coordination between multiple health care personnel. For example, in one instance where the physician misdiagnosed an ectopic pregnancy, he had failed to receive relevant laboratory reports. Notwithstanding the categorization of this failure as a diagnostic error, grouped under patient management problems, a system which would place positive pregnancy test results into the hands of the responsible

physician would have averted the claim. The authors concluded that system failures may play a more crucial role in spawning medical malpractice claims than is presently accepted.

FAMILY PRACTICE RISK MANAGEMENT

Medical malpractice claims are difficult for physicians on both a professional and an emotional level. The author of this article, the professor and chair in the Department of Family and Community Medicine at Bowman Gray School of Medicine of Wake Forest University, surveys the current system for resolving claims and identifies the most common types of claims.

According to this author, the most common types of claims can be categorized as follows: failure to diagnose or delay in diagnosis (particularly hemorrhage, fractures or cancer); negligent treatment with drugs; failure to obtain a timely consultation; negligent obstetric management; negligent management of a procedure; and failure to obtain informed consent.

Statistically, more than one in three family physicians has been sued, while internists (including those in subspecialties) are sued slightly more often. Most physicians, during their professional careers, will deal with malpractice issues either directly, as a defendant, or indirectly, as an expert witness or consultant.

Regardless of outcome, malpractice suits are emotionally traumatic for physicians, and those who have been sued have higher rates of depression and suicidal ideation. Many estimate that the result is "defensive medicine," which itself incurs an annual cost in excess of $10 billion.

Finally, limited risk management strategies are advanced. While it is observed that even the best risk management practices do not prevent all claims, good medical care is cited as the most effective strategy, along with frequent consultation when indicated, and close monitoring of patients receiving drugs. Naturally, documentation is crucial, and the suggestion is made that entries in the record be not only legible and accurate, but also consistent and objective, with no extraneous comments or subjective impressions. Other strategies cited include careful written documentation of the termination of the physician-patient relationship, recorded after sufficient notice to the patient and adequate time for him to find another physician.

The author closes by advocating that physicians give prompt notification of adverse patient outcomes, when so requested by insurers, and consider retaining an attorney not associated with the insurance company to represent his interests. Lastly, the physician is advised to refrain from directly contacting the patient or the patient's attorney in order to explain the situation or clarify matters.

DIAGNOSTIC ISSUES DOMINATE MEDICAL LIABILITY

According to a large civilian malpractice insurer, the St. Paul Fire and Marine Insurance Company, diagnostic issues now account for the greatest number of claims reported since 1989, as well as the highest cost associated with settlement.

Malpractice claims alleging failure to diagnose account for 27 percent of total claims filed, and 35 percent of total costs. Claims involving surgical issues, on the other hand, account for about 25 percent of the reported claims and 20 percent of the costs. (See Table 2)

Within the failure to diagnose category, diagnostic issues involving cancer comprise the most frequent allegation and account for 31 percent of the cost of this type of claim. Since the evaluation of a patient's symptoms is often performed in a physician's office, it is not surprising that a clear majority of these claims (more than 70 percent) involve alleged negligence in an outpatient clinic or a doctor's office. (See Table 3)

CLAIMS REPORTED IN 1989 AND 1990 BY PHYSICIANS INSURED BY THE ST. PAUL FIRE AND MARINE INSURANCE COMPANY (N=7,233)

ALLEGATION GROUP	PERCENT OF TOTAL CLAIMS	PERCENT OF TOTAL INCURED COST
Failure to Diagnose	27.4	34.8
Improper Treatment	26.9	30.4
Surgery	25.3	21.5
Anesthesia	4.1	4.0
Other Issues	16.3	9.3

TABLE 2

TOP FIVE FAILURE TO DIAGNOSE CLAIMS REPORTED IN 1989 AND 1990 BY PHYSICIANS INSURED BY THE ST. PAUL FIRE AND MARINE INSURANCE COMPANY

ALLEGATION	NUMBER OF CLAIMS
Failure to Diagnose Cancer	498
Failure to Diagnose Circulatory Problems/ Thrombosis	181
Failure to Diagnose Fracture/Dislocation	179
Failure to Diagnose/Lack of Attendance	146
Failure to Diagnose/Infection	122

TABLE 3

REFERENCES

1. Kravitz RL, Rolph JE, and McGuigan K. Malpractice Claims Data as a Quality Improvement Tool. I. Epidemiology of Error in Four Specialties. JAMA 1991; 266: 2087-2092.

2. Bowman MA. Risk Management and Medical Malpractice. American Family Physician. 1992; 45: 1741-1745.

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